PEEPERS OPTICAL

REGISTRATION FORM

Today's date:				

PATIENT INFORMATION

Patient's last name: First: Middle:			Sex: ❑ M ❑ F	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Social Security no.:	Birth date: / /	Age:
Street address:		Primary phone no.: ( )	Would you like text messages? ❑Yes ❑No	
Unit/Apt:	City:	State:	ZIP Code:	
Occupation:	Employer:	Email Address:		

How did you hear about our office? (please check one box):

❑ Internet ❑ Insurance Plan ❑ Groupon/Living Social ❑ Close to home/work ❑ Yelp ❑ Friend/Family _____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Vision Insurance : ❑ VSP/Cigna Vision ❑ Eyemed ❑ Superior Vision ❑ Humana ❑ Other ❑ None

Medical Insurance: ❑ United Healthcare ❑ BCBS/ Anthem ❑ Rocky Mountain ❑ Aetna ❑Cigna ❑ Other

Patient's relationship to subscriber: ❑ Spouse ❑ Child ❑ Other

Subscriber's name: ❑ Self	Policy no.:	Group no.:	Birth date: / /	Subscriber's S.S. no.:	Employer:

IN CASE OF EMERGENCY

Emergency Contact:	Relationship to patient:	Primary phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize PEEPERS OPTICAL or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*